STATEMENT OF
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THE AMERICAN LEGION
BEFORE A
JOINT SESSION OF THE
VETERANS' AFFAIRS COMMITTEES
UNITED STATES CONGRESS
ON THE
LEGISLATIVE PRIORITIES OF THE AMERICAN LEGION

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Messrs. Chairmen and Members of the Committees:

As the newly elected National Commander of The American Legion, I thank you for the opportunity to present the views of its 2.8 million members on issues under the jurisdiction of your committees. At the conclusion of The American Legion's Eighty-Third National Convention in San Antonio, Texas, over 4,000 delegates adopted 48 new mandates for the 107th Congress. These mandates are added to the current legislative portfolio of The American Legion.

The American Legion greatly appreciates the actions of these committees in shaping the rights and benefits of this nation's veterans. Fortunately, for the veterans' community, both committees have distinguished members and dedicated professional staff willing to work in a bipartisan manner to address important issues concerning veterans' health care, compensation and pension, education, burial and survivor's benefits. The American Legion believes Congress has a unique obligation to ensure that veterans' benefits are protected and keep pace with the needs of all veterans and other beneficiaries in a changing social and economic environment.

The American Legion greatly appreciates the actions of all Members of Congress regarding the increase in VA Medical Care funding for Fiscal Year (FY) 2001 and the focus on increases in FY 2002. The American Legion believes such increases were long overdue and has allowed VA to better meet some of the needs of veterans seeking care for their many medical problems. The American Legion believes VA should continue to receive appropriate funding in order to maximize its ability to provide world-class health care to the large number of aging veterans, while still maintaining services to a younger cohort of veterans who are using VA for the first time.

Just like the Medicare and Medicaid programs, the VA healthcare budget requires an annual increase to maintain its existing service level and to fund new mandates. For years, VA managers were asked to do more with less. The recent funding increase now allows the Veterans Health Administration (VHA) to catch up with the growing demands placed upon the system and repair some of the problems related to long patient waiting times and limitations on access to care.

The overall guiding principle for VA must be improved services to veterans, their dependents, and survivors. This will require improving access and timeliness of veterans' health care; increasing quality and timeliness in the benefit claims process; and enhancing access to national and state cemeteries. Specific American Legion objectives for Congress include:

- **Sound VHA funding for long-term strategic planning and program performance measurement,**
- **Additional revenue for staff and construction,**
- **Medicare subvention,**
- **Pilot programs for certain dependents of eligible veterans,**
- **VA and DoD sharing,**
- **Reduce the claims backlog,**
- **Enhance the Montgomery GI Education Bill,**
- **Repeal bar to service-connection for tobacco-related illnesses,**
- **Increase the rate of beneficiary travel reimbursement, and**
- **Allow all third-party reimbursements collected by VA to supplement, rather than offset, the annual Federal discretionary appropriations.**

The American Legion offers the following budgetary recommendations for FY 2003:

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2003

Program	FY 2001	HR 2620 FY 2002	S 1216 FY 2002	Legion's FY 2003 Request
Medical Care	$20.2 billion	$21.3 billion	$21.4 billion	$23.1 billion
Medical and Prosthetics Research	$350 million	$371 million	$390 million	$420 million
Construction				
• Major	$ 66 million	$183 million	$155 million	$310 million
• Minor	$166 million	$179 million	$179 million	$219 million
State Extended Care Facilities	$100 million	$100 million	$100 million	$110 million
State Veterans' Cemeteries	$ 25 million	$ 25 million	$ 25 million	$ 30 million
NCA	$109 million	$121 million	$121 million	$140 million
General Administration	$1.1 billion	$1.2 billion	$1.2 billion	$1.3 billion

MEDICAL CARE
VETERANS HEALTH ADMINISTRATION

The past eight years have witnessed a significant reorganization and realignment of VHA resources and programs. Many dramatic changes were initiated to improve VA's ability to meet the healthcare needs of the veterans' community. Now, over four million veterans are enrolled in the VA healthcare system and even more veterans would come, if additional resources were available to cover the cost of their care. VA continues to provide outstanding quality care that is recognized and praised by healthcare critics internationally. VA's medical research is still, dollar-for-dollar, the nation's best investment. According to The American Legion's most recently completed VA Local User Evaluation (VALUE) survey, 3,400 veterans who responded , there was general agreement that quality, efficiency and effectiveness are the hallmarks of today's VHA.

Congress must continue to support increased VHA funding to maintain a strong and viable healthcare system. There are precious little additional efficiency savings expected throughout the system. Yet, those veterans now enrolled and using the system will continue to rely on VHA in the foreseeable future. The American Legion believes that all veterans should maintain their eligibility status and none of the priority seven veterans should ever be disenrolled to enable VHA to be able to stay within the constraints of its budget. The American Legion believes that a strategic goal for VHA should be to seek opportunities to increase funding sources, both appropriated and nonappropriated. However, The American Legion opposes VA's effort to generate new revenue by shifting the cost of care to the veteran by increasing the pharmacy co-pay from $2 to $7, an increase of 250%, especially when VA did not spend its full estimate on pharmaceutical products.

VHA has six strategic goals to be accomplished by 2006:

- Put quality first,
- Provide easy access to medical knowledge, expertise and care,
- Enhance, preserve and restore patient function,
- Exceed customers' expectation,
- Maximize resource use to benefit veterans, and
- Build healthy communities

The American Legion believes these are important goals, we believe VHA must explore all opportunities to develop alternative revenue sources to complement its annual appropriations. To do less will continue to force VHA to rely solely on the annual budget process to establish patient treatment priorities. If future funding does not keep pace with the needs of veterans who seek treatment through VHA, the current access for all seven-priority groups is at risk. The American Legion would strongly oppose the disenrollment of any veteran currently using VA health care or the ban on new enrollment. It is essential that the FY 2003 budget be sufficient to allow the VHA to continue to provide high-quality health care to all of our deserving veterans.

VA/DOD SHARING

VHA and DoD medical systems are the largest federal healthcare providers in this country. VHA has 172 medical centers, 900 ambulatory clinics, 134 nursing homes, 40 domiciliaries, 72 comprehensive home-care programs, and 206 counseling centers. DoD has 15 medical centers, 66 Community Hospitals, and 489 clinics. Combined, the two agencies have 12 million enrolled beneficiaries. Clearly, there are multiple venues for sharing. The American Legion recognizes the current benefits from these sharing agreements and the potential gains from additional efforts. Sharing agreements augment services and build on the respective strengths of the participants.

With the advent of the first joint venture and the emergence of VA and DoD medical sharing agreements, The American Legion had the foresight in May 1989 to establish its own Special Task Force on Veterans' Medical Care to review the effectiveness of these cooperative efforts. The initial Task Force report of September 1989 to the National Executive Committee stated that the sharing agreements, "represented positive adjuncts to efforts to meet the mission of medical centers. They enhance the availability and variety of services provided to veterans, and they can provide avenues to increase joint education and research endeavors." The report also cautioned, "adequate funding must be provided to both agencies in order for each to sufficiently treat their primary beneficiaries. Sharing agreements in and of themselves are not the answer to improving the decremental VA and DoD funding." This is as true today as it was twelve years ago.

Currently, VA and DoD sharing occurs among 165 VAMCs and most military medical treatment facilities. VA and the military have agreed to share 7,963 services covering a broad range of hospital related activities. Both Departments are exploring ways to improve coordination of service delivery in such areas as long-term care, pharmacy, chiropractic services, and radiology.

There are seven joint venture sites where VA and DoD are co-located on the same campus:

- VA New Mexico HCS & Kirkland AFB (Albuquerque)
- El Paso VAHCS & William Beaumont Army Medical Center (Texas)
- VA Key West & Navy (Florida)
- VANCHCS & Travis/Mather AFB (California)
- Tripler Army Medical Center & VAMROC Honolulu (Hawaii)
- Nellis AFB & Southern Nevada VAHCS (Las Vegas)
- Elmendorf AFB & VAMROC Anchorage (Alaska)

Last Congress, major legislation was enacted granting Tricare for Life and expanding greater access to all DoD pharmacy benefits for Medicare-eligible military retirees and their Medicare-eligible dependents. Meanwhile, the Veterans Millennium Health Care and Benefits Act (PL 106-117) mandated VA and DoD to enter into an agreement to reimburse VA for the cost of providing care to enrolled, Priority 7 retired service members.

VA and DoD are drafting instructions to improve billing and collections; especially regarding money owed VA Medical Centers as a result of DoD's converting supplemental care

money to Tricare on October 1, 1999. The amount of money generated from providing services to Tricare beneficiaries through January 2001 was $2,985,784, an increase of $1,420,969 from 2000. This represents a 90.8% increase from the previous year and reflects the additional reimbursements earned from increased joint sharing services.

In May 2001, The American Legion visited 3 joint ventures (Michael O'Callahan Federal Hospital, Las Vegas, NV, William Beaumont Army Medical Center, El Paso, TX and Kirkland Air Force Base, Albuquerque, NM) in an attempt to better understand the implications and intricacies of VA and DoD sharing. In general, The American Legion received positive feedback about the opportunities and results of the sharing agreements. There is a clear indication of benefits for both systems.

The American Legion is very impressed with the joint venture sites it has visited and other sharing arrangements it has reviewed. The American Legion encourages VA and DoD to continue to explore more avenues for cooperation and to assist other areas of the country in formulating and negotiating these opportunities. The American Legion believes there are many more of these opportunities out there to be developed. The American Legion believes that the number and types of sharing agreements as indicated by the amount of dollars exchanged is minor, relative to the overall budgets for each Federal agency. Finally, The American Legion sees this as the appropriate time to ask Congress to consider legislation that would allow VA to bid on the Tricare contracts. The American Legion envisions a future for federal health care that will allow each of the unique missions of the different departments to be enhanced by a closer relationship and increased mutual support.

Indications of the continued interest in VA and DoD sharing initiatives included visits by military and congressional representatives during the past year to the current joint venture sites, and a GAO survey of VA medical facilities regarding the potential for further sharing opportunities. On Memorial Day 2001, the Administration and congressional interest culminated as President Bush established a Federal advisory committee, "In order to provide prompt and efficient access to consistently high quality health care for veterans."

The mission of the presidential task force has three major components:

1. Identify ways to improve veterans' benefits and services through better coordination of the two departments;
2. Review barriers and challenges that impede coordination and identify opportunities to improve business practices to ensure high quality and cost effective health care; and;
3. Identify opportunities for improved resource utilization between VA and DoD to maximize the use of resources.

The American Legion supports these goals. There are already several joint venture models in the field, in which local personnel have been able to negotiate based on the healthcare demands in their areas.

The American Legion supports the recently introduced H.R. 2667, Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001, which would provide for a joint Department of Defense and Department of Veterans Affairs

demonstration project to identify benefits of integrated management of healthcare resources of those departments. The American Legion believes that this Bill is another step in the right direction to providing quality, timely, and affordable health care to our nation's veterans.

On another related matter, in the FY 2002 budget request, the President recommended that any veteran eligible for both VHA and Tricare enrollment must choose one or the other healthcare system, but not both. Furthermore, the President recommended the transfer of $235 million from VHA medical care to DoD medical care because of the estimated number of military retirees currently enrolled in VHA who would choose. The American Legion adamantly opposes both recommendations for several very cogent reasons:

- VHA currently is not a family healthcare plan;
- Veterans with service-connected medical conditions may need the specialized services provided by VHA that are unavailable through DoD;
- VHA offers other specialized services not available under Tricare – i.e., long-term care, blind rehab, and spinal cord injury;
- All veterans are eligible to enroll in VHA due to their honorable military service – this is an earned benefit;
- When Tricare was created and Medicare-eligible military retirees could not enroll in Tricare, no similar transfer of healthcare dollars was made from DoD medical care to VHA medical care; and
- Military retirement is not a criterion for healthcare in the VHA; therefore, it is not a factor in the calculation of annual discretionary VHA appropriations.

TRICARE

Tricare continues to face many challenges in providing and maintaining a quality healthcare delivery system for active duty military personnel, military retirees, and dependents. Tricare continues to fail in meeting the expectations of its beneficiaries. The American Legion is very concerned about how DoD is going to fix the problems that beset Tricare.

Tricare continues to experience:

- Infrastructure and financial problems,
- Problems with provider networks-resulting in weak network links to subcontractors,
- The inability to attract and retain qualified healthcare contractors,
- No financial tracking system outside of the military treatment facilities,
- Difficulties in processing claims in a timely manner,
- Tricare lacks portability between all 12 regions, and
- Military retirees and their dependents are required to pay an annual enrollment fee.

The American Legion believes that VHA can greatly assist DoD through expanded authority to provide care to Tricare beneficiaries. With limited budgets, both VA and DoD must discover innovative ways to provide care to active duty personnel, to all veterans and military retirees, and to eligible dependents.

With the passage of the Veterans' Millennium Health Care and Benefits Act (PL 106-117), Congress recognized the need for having VHA play a greater role in the treatment of Tricare beneficiaries. This legislation requires VA and DoD to enter into an agreement to reimburse VA for the cost of care provided to retired service members who are eligible for Tricare and who are enrolled as Priority 7 veterans. These veterans are not required to pay VA inpatient and outpatient copayments.

The American Legion strongly recommends that Congress allow VA to become a primary contractor for the DoD healthcare system. Legislation would be required that would allow VA to act as a primary contractor and be able to compete with the private sector for these contracts. Instead of VA being the subcontractor, it would become the contractor using VHA medical facilities to provide care to Tricare beneficiaries. This level of cooperation would go a long way in reducing costs for all three Federal agencies (DoD, VA, and the Centers for Medicare and Medicaid Services) and would provide consistent, coordinated quality health care for the entire patient population.

HEPATITIS C

VA and The American Legion continue to do outreach to veterans to educate them about hepatitis C virus (HCV). In looking at the networks, The American Legion notes that there is clearly a disparity in the outreach activities throughout VHA. The American Legion has augmented this effort with its own HCV poster campaign and will be distributing 50,000 HCV pamphlets created with the American Liver Foundation. The American Legion identified 30 VHA medical facilities aggressively identifying and treating veterans for hepatitis C. This disparity not only varies from VISN to VISN, but from medical facility to medical facility. The most obvious cause for this variance is the staffing shortage at some VA medical facilities.

Nationally, there is an overall nursing shortage that adversely affects all elements of the healthcare industry and VHA has not been exempt. This lack of staffing is effecting VHA's infectious disease clinics as well. There is also a shortage of infectious disease specialists in some areas of the country, making it difficult to recruit and retain physicians and nurses in this unique sub-specialty. The American Legion believes patient treatment compliance would improve if VHA provided a stronger multidisciplinary approach and had appropriate staffing to accomplish this critical mission. Staffing is a key element to antiviral drug therapy compliance. When patients are experiencing discomfort and adverse side effects, they need immediate access to the discipline that can help them address those problems. If a patient is experiencing depression and the next available appointment in the mental health clinic is 90 days away, the patient will probably not be able to tolerate the regimen and will stop taking prescribed medication.

GAO reported that VA's FY 2000 budget had assumed that nearly 17,000 veterans would be treated for HCV and that 70 percent would complete a one-year antiviral drug therapy regimen. However, only 4,455 veterans received the antiviral drug therapy. Regrettably, most dropped out of the treatment program before six months. The American Legion finds this unacceptable and very concerning. It is estimated that 6.6 percent of the veterans' population are at risk for being hepatitis C positive. The fact that less than 5,000 veterans even began treatment

and hardly any finished is a glaring deficit in the number of veterans receiving and being able to comply with appropriate treatment. The American Legion recommends VA outreach to educate providers and patients to improve screening and treatment access.

NURSING SHORTAGE

The American Legion is concerned that the shortage of nurses within the Department of Veterans Affairs (VA) will adversely effect patient care. Sufficient and high quality nursing care is one of the most important and necessary components of VHA's healthcare delivery system. Nurses continue to serve as the backbone of direct patient care.

Articles appearing in nursing publications argue that *the nurse shortage is evident by rising nursing vacancy rates, which have resulted in closed beds, non-urgent surgery cancellations, and the diversion of patients from emergency rooms*. Moreover, the nursing shortage can be attributed to the diminishing supply of new talent entering the profession coupled with a growing demand for healthcare services.

Overall, the VA nursing turnover rate was 9.5 percent, while the percentage of new nurses brought on board was 9 percent. VHA's turnover rate of 9.5 percent compares favorably to the US turnover rate of 15 percent. Nevertheless, VHA is still experiencing nursing shortages. This often involves positions with special qualifications that vary by region. However, The American Legion has seen several long-term care programs, for example, the nursing homes in Tuskeegee, AL; Augusta, GA; and Amarillo, TX, that are not at capacity due to the lack of nursing coverage, and as previously noted has impacted HCV care. There are also difficulties recruiting Intensive Care Unit (ICU) nurses. When VHA has to divert veterans from emergency rooms, community facilities are often doing the same.

The American Legion commends Congress for passing PL 106-419, which provided the framework to help revitalize VHA salaries in a number of disciplines, including nursing. While there are reports that some stations still have work to do to resolve significant salary discrepancies between VHA and the community, this is only one component of the retention and recruitment equation.

A study by the Center for Health Economics and Policy at the University of Texas Health Science Center in San Antonio, Texas identified three essential factors that affect the nationwide retention of nurses:

- *Work environment practices that may contribute to stress and burnout,*
- *The aging of the RN workforce combined with the shrinking applicant pool for nursing schools, and*
- *The availability of other career choices that makes the nursing profession less attractive.*

Other factors cited most frequently for leaving nursing included:

- *lack of time with patients,*
- *concern with personal safety in the healthcare setting,*
- *better hours outside of nursing, and*

- *relocating.*

It is clear the nursing profession faces significant challenges imposed by an aging workforce. The average age of VHA nurses is 46 years. The increasing medical care demands of an aging population, a declining interest in the profession, prompted by more preferable career alternatives for women, and a perceived lack of appreciation and respect for the profession add to these challenges. In a survey released in February 2001 by the American Nurses Association*, 56 percent of those surveyed said they would not recommend their profession to their children or their friends.*

VHA has two committees looking at the nurse shortage and they will provide proposals to address the needs and issues within VHA. However, VHA should have the capabilities to aggregate data relative to its nursing coverage to include the number of vacant positions in the system. Data would also be useful regarding the associated consequence of those vacancies – bed closures, delayed delivery of care, etc. This would help to clarify and define VHA's needs. VHA is currently working to improve in this area.

VHA should continue to explore ways to enhance the work environment. Morale among nurses is deeply impacted by the amount of non-nursing functions they are required to perform. Therefore, it is imperative VHA make sure there is sufficient clinical and ancillary support to maximize the nursing skills of nurse providers. Similarly, local facilities have a number of practices to facilitate hiring, but their use varies across the country reflecting local decisions on the use of limited resources. The ability to provide recognition rewards, can be affected by the local budget. Thus, adequate funding is imperative.

VHA must draw upon its models of collaborative efforts to use the talent among its clinical staff to help address the issues that surround the availability of teachers for nursing programs. VHA continues to be a leader in the fields of the electronic medical record and patient safety initiatives. Finally, VHA must ensure that such efforts are widely recognized because this will enhance its ability to attract those looking to be part of the cutting edge of nursing practice.

The American Legion is appreciative of the many contributions of VHA nursing personnel and recognizes their dedication to veterans who rely on VHA health care. Every effort must be made to recognize, reward and maximize their contributions to the VHA healthcare system.

MENTAL HEALTH

Veterans diagnosed with mental illness are truly those who suffer the consequences of war and military service in the most subliminal ways. In our society, which often attaches stigma and bias to the psychiatric realm, these veterans truly become the most vulnerable, especially as they age. Overall, they are at greater risk for homelessness, substance abuse, incarceration and further traumatization. Serious mental illness is not easily treated. It is chronic and complex in nature and requires medication maintenance, therapeutic interventions, intensive case management, socialization and economic education, and social support. The disorders

identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association can add up to a very expensive lifetime cost per patient.

For these reasons, The American Legion views this population as needing our special attention and protection and feels Congress shared this position when it created the Capacity provision under the 1996 P.L. 104-262. Unfortunately, VA was left to define capacity, and they did so by looking at the number of patients treated and the dollars expended on their care. The American Legion has always been dismayed that technical quality and patient satisfaction are not part of that formula**.**

The American Legion, as a member of the Consumer Liaison Council of the Committee on the Care of the Severely Chronically Mentally Ill (SMI) Veteran supports their conclusion that based on FY 2000 data, VA is still not in compliance with the capacity provision. The American Legion first offered testimony on VA's non-compliance with the capacity provision on July 23, 1998. In spite of the best efforts of the SMI Committee, VA has not done what it should do in order to be in compliance with the law. VA has closed 64 percent of its psychiatric beds, which included closing 90 percent of its substance abuse beds. The promise from VA was that these dollars would be reinvested in outpatient services, domiciliary care and mental health primary care in the community. However, history is repeating itself.

Thirty years ago, the states promised to deinstitutionalize their large psychiatric facilities to open more community clinics and group homes, but never did, leaving individuals suffering from psychiatric conditions, homeless, incarcerated, or dead. It would seem that the VA is on this very same course. Since 1996, VA is treating 12 percent less seriously mentally ill patients and spending 37 percent less. VA has opened up several hundred new CBOCs across the country, but not nearly enough of these offer mental health services. It is estimated that one third of the homeless in America are veterans and that 12 percent of the incarcerated population are veterans according to a January 2000 Department of Justice study. The American Legion fears that these numbers will increase, as fewer services are available from VA.

As part of its site visit process, The American Legion has documented mental health service inadequacies all across the country. There is still no long-term mental health care in some VISNs. The functional capacity of homeless veterans suffering from substance abuse and/or other illnesses is greatly impaired when the community they will need to transition back into is hundreds or thousands of miles away. This surely cannot be anyone's idea of quality mental health services. The American Legion documented the concern in the Chicago area over the lack of mental health services and the increase in veteran incarceration rates. There are Legionnaires who are concerned that as VA has closed its substance abuse program and detoxification is being done on an outpatient basis. In other VISNs patients are being denied equal access to all of the atypical anti-psychotic medications. The American Legion has always been opposed to a formulary process or practice guidelines that come between a physician and his/her patient. The American Legion recognizes formularies and guidelines can be useful management and training tools, but the expertise of the doctor and the needs of the patient should not be secondary.

The American Legion offers the following recommendations to improve services to seriously mentally ill veterans:

1. The SMI Committee reporting status should be raised to the level of the VA Secretary.

2. The consumer council should have the same status as the VA employees on the committee.

3. The Office of the Inspector General should also be assigned the task of providing evaluation of the networks for capacity compliance.

4. The capacity definition created by VA should go beyond numbers of patients treated and cost per patient. There needs to be accountability to the quality of care and the satisfaction of the patients.

5. Staffing patterns need to improve for there to be capacity compliance. It is not enough to open CBOCs and have programs. Clinics and programs need to be well staffed with well trained mental health providers who are specialists in case management, substance abuse, traumatic stress, rehabilitation and psychopharmacology. VA should be able to offer incentives to new hires and employees who maintain certifications or can document on-going training in these areas above and beyond hospital credentialing and privileging processes.

6. Since dollars have not been reinvested in outpatient care or the CBOCs, and in many areas there seems to be a shortage of inpatient beds, VA should reopen, at minimum, ten percent of its acute psychiatric and detoxification beds. Veterans miss this level of care and it is costing them their sobriety, their homes, their families, their freedom and their lives.

7. Psychiatrists must be able to prescribe medication that is in the best interest of their patients without the fear of poor performance evaluations and disciplinary actions. Psychiatrists, in a working relationship with their patients, are the best and most cost efficient treatment assets within VA. Properly trained and well supported, physicians and other providers make decisions in the best interest of the patient and should not be second-guessed by administrators and financial officers. "Getting it right the first time" is truly the best approach to medicine. Restrictions that require patients to fail or be unresponsive are immoral and inhumane. The American Legion recognizes that these pharmaceuticals can be expensive, but are not nearly as expensive as prolonged inpatient stays, incarceration, or prolonged rehabilitation.

The American Legion is hopeful that the Congress will act to protect veterans who have given so much of who they were in service to this country and will consider the recommendations it has made. Veterans deserve peace of mind.

POST TRAUMATIC STRESS DISORDER

National Center for PTSD

The American Legion has long recognized the healing needs combat veterans have from the emotional scars of war. Post Traumatic Stress Disorder (PTSD) compensation and treatment have been on The American Legion agenda even before it was a recognized diagnosis. The American Legion has continued this commitment to veterans suffering from PTSD through site visits it conducts throughout the year to programs at VA medical centers and by auditing training offered by the National Center for PTSD.

The National Center has done remarkable work in research and VA is the cornerstone in trauma treatment around the world. However, there seems to be a growing gap between the expertise within the VA and new employees and employees that have been downsized from one service and transferred to psychiatry to keep their jobs. These are the employees who could benefit the most from National Center training, consultation and mentorship, but few have taken advantage of it because of budgetary limitations on travel and education expenses. The National Center for PTSD budget has been flat-lined for the last seven years. Its travel budget was larger in 1993 when there was almost half the staff than in 2001. The National Center could benefit from a budgetary increase in order to provide additional training and educational services to the field. A nonprofit program should be established that would allow the National Center for PTSD to raise funds for educational activities.

Readjustment Counseling Services

The American Legion has been a longstanding advocate of the Readjustment Counseling Services (RCS) dating back to the 1970's. RCS has remained a primary provider of PTSD counseling for combat and other traumatized men and women who served this country. As VA has shifted its focus to outpatient care, RCS has led the way in providing PTSD care. In spite of the fact that they treat more and more veterans each year, RCS has not seen a substantial budget increase in many years. The American Legion supports an increase for the RCS program to ensure that younger veterans who served in the Gulf war and in more recent peacekeeping missions will have the same access to care that the Vietnam veteran generation has come to know.

GULF WAR VETERANS' ILLNESSES

The American Legion continues to actively support Gulf War veterans and their families, as it has since August 1990. The American Legion created two particular programs specifically for Gulf War veterans, the Family Support Network in October 1990, and the Persian Gulf Task Force in October 1995. Today, The American Legion serves Gulf War veterans and their families at the community, state, and national levels through it's 15,000 local posts and an array of programs and services.

Thousands of Gulf War veterans, who suffer undiagnosed illnesses with a range of symptoms, known as "Gulf War veterans' illnesses," are not receiving adequate care or

compensation from VA and/or DoD. In 1994, hallmark legislation in the form of PL 103-446 was enacted to ensure compensation for ill Gulf War veterans suffering from unexplained illnesses. Yet, to date, most Gulf War veterans who have filed a claim for undiagnosed illness compensation have been denied service connection for those conditions. Although PL 103-446 looked good on paper, a dismal seventy-five percent denial rate is the reality for our sick Gulf War veterans trying to receive VA service connection for Gulf War-related undiagnosed illness.

This past summer, The American Legion testified before both the House and Senate Veterans Affairs Committees in support of pending legislation to amend the current undiagnosed illness law (38 U.S.C. § 1117). We have also voiced our concern over the inconclusive nature of Gulf War research to date and the resulting need to extend the current presumptive period for undiagnosed illness compensation claims.

The American Legion also urges Congress to continue aggressive oversight of the implementation of key provisions of PL 105-368. In particular, we note that, as of this date, VA has failed to establish a research advisory committee in accordance with this law.

Considering all of the mitigating factors with VHA, The American Legion recommends $23.1 billion in medical care funding in FY 2003.

MEDICAL AND PROSTHETIC RESEARCH

The contributions of VA medical research include many landmark advances, such as the successful treatment of tuberculosis, the first successful liver and kidney transplants, the concept that led to the development of the CT scan, drugs for treatment of mental illness, and development of the cardiac pacemaker. The VA biomedical researchers of today continue this tradition of accomplishment. Among the latest notable advances are identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, and potential genetic therapy for heart disease. Many more important potentially groundbreaking research initiatives are underway in spinal cord injury, aging, brain tumor treatment, diabetes and insulin research, and heart disease.

Dollar for dollar, others recognize VA as conducting an extraordinarily productive research program. Currently the VA devotes 75 percent of its research funding to direct clinical investigations and 25 percent to bioscience.

The Quality Enhancement Research Initiative (QUERI) is the highest priority within the VA's Research and Development program. The Institute of Medicine has recognized this program as the best of its kind. QUERI is a multidisciplinary, data-driven national quality improvement program designed to promote the systematic translation of evidence into practice. In other words, "putting research results to work." Currently, QUERI focuses on 10 priority conditions. These conditions include congestive heart failure, heart disease, mental health, substance abuse, HIV/AIDS, diabetes, stroke, spinal cord injury, dementia/Alzheimer's and prostate cancer. Without sufficient funding, VA will not be able to continue all of the QUERI

initiatives that involve new technology and the cutting edge of scientific advances. This will have a direct impact on the rapidly aging veteran population.

VA's overall research program requires a significant increase in funding above current levels in each of the next several years to perform important research and evaluation studies.

The American Legion recommends $420 million for the research budget in Fiscal Year 2003.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

MAJOR CONSTRUCTION

The VA major construction program is woefully underfunded. The major construction appropriation over the past few years has allowed for only one or two projects per year. Meanwhile, the number of priority projects continues to mount. For FY 2001, 16 major ambulatory care or seismic correction projects were submitted to OMB. Of this number, only one major VHA project was recommended. For FY 2002, 28 major projects have been submitted for funding.

Over the past several years, The American Legion has testified that VA's major and minor construction appropriation must include all infrastructure priorities. Unfortunately, over the past several years, VA has not received appropriate funding. The American Legion applauds Chairman Smith's effort to secure an additional $300 million for the Veterans Hospital Emergency Repair Act (H.R. 811) which would authorize immediate repairs and critically needed improvements to VA medical facilities.

Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse. Currently, the VHA has identified 890 buildings in its inventory as being at risk. Of those 890, 560 are identified as Essential – defined as bed, clinic, psychiatric, research, boiler plant, etc. Additionally, VHA has identified 67 patient care and other related use buildings as Extremely High Risk – danger of collapse or heavy damage. Along with the necessary ambulatory care and patient safety projects, it will require well over $250 million to address VHA's current major construction requirements.

The CARES program has impeded construction projects throughout VHA. Many much needed construction projects that would maintain and update VHA's infrastructure are being put on the back burner while CARES awaits full implementation. The American Legion fears that the CARES process does not allow for the local VA managers to implement the facility improvement projects that they know are necessary to maintain a functional service delivery system.

The American Legion recommends $310 million for major construction in Fiscal Year 2003.

MINOR CONSTRUCTION

The American Legion believes that Congress must be consistent from year to year in the amount invested in VHA's infrastructure. Annually, VHA must meet the infrastructure requirements of a system with approximately 5,000 buildings, 600,000 admissions and over 35 million outpatient visits. To do so requires a substantial inventory investment. The FY 2001 appropriation of $166 million for minor construction was not nearly enough to meet future physical improvement needs. With the added cost of the CARES program recommendations and the nearly $42 million request for minor upgrades in the research facilities, it is essential that funding be increased considerably from that of past fiscal years. It would be foolish to reduce this investment.

The American Legion recommends $219 million for minor construction in Fiscal Year 2003.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES PROGRAM (CARES)

The Department of Veterans Affairs (VA) developed the Capital Asset Realignment for Enhanced Service (CARES) study because it wanted to be able to identify and best utilize its buildings and other spaces to serve veterans. This is to be a multiple phase evaluation process of VA assets. According to the General Accounting Office, (GAO) VA has 4,972 buildings and 16,600 acres of land. In the last decade VA has dropped its inpatient hospital utilization by 20,000 patients a day. Even though more veterans have enrolled in VA, there are less needing hospital admissions due to changes in legislation that allow veterans to access care on an outpatient basis. The GAO expects that there will be over a 30 percent decline in veterans using VA in the next 30 years. VA reports that its buildings are aging and many are outdated and cannot be modernized to fulfill the requirements of today's medical technology. The American Legion believes that CARES is budget driven and will result in more of VA care turned over to the private sector. The American Legion Resolution #3 opposes the systematic closure of VA hospitals.

There is a World War I veteran in Illinois who can recall a time when there was no VA hospital system. He remembers when private hospitals were not able to care for the special needs of wounded and disabled veterans, and the VA hospital system was created, to fill that void. He knows a lot has changed, especially in medicine, but still wants to know how the private sector will now be able to do the job that they could not do then. This may seem to be a simplistic view of the current CARES study that has recently taken place in VISN 12, but it is apropos in its historical insight into the future trend of the VA healthcare system. It is a clear reminder of why the VA was created in the first place. The private sector cannot care for the special needs of the veteran population. This premise has not changed. VA special programs in prosthetics, blind rehabilitation, spinal cord injury, and mental health are unduplicated in the private sector. In many areas of the country, VA is the leader in quality care benchmarks. Even when benchmarked against Medicare performance measures, VA outperforms on average by at least 50 percent.

Therefore, as The American Legion has reviewed the CARES process, as it has rolled out in VISN 12, there are several concerns it has had with the methodology and the options developed. In spite of the criteria established and the sensitivity analysis conducted, there are several assumptions the contractor, Booz-Allen and Hamilton (BAH), has made that The American Legion refutes. In addition, BAH relies heavily on VA's own data. The American Legion has experienced several problems with VA data in that it is often skewed by miscoding, under and over reporting and inconsistencies. This makes generalizations about length of stay and cost per patient suspect. The BAH methodology does not give mental health enough attention and will effect much of their other assumptions about inpatient lengths of stay and outpatient availability.

Second, VA is not and should not be run like a managed care organization. Managed care turns a profit by enrolling the healthiest of beneficiaries and rationing their care. VA's primary care patient population is going to present with more chronic illnesses and more complex needs than the employee-based healthcare plan user. At VA, there are going to be patients with more complicated social situations. BAH devotes little attention to VA's homeless and psychiatric populations. BAH looks at management from a Degree of Community Management (DoCM) that compares three different models: Loosely Managed, (fee-for service), Moderately Managed, (mixed model) and Well Managed (managed care organization). BAH seems to favor the later. BAH concluded that almost 48 percent of the total VA days are in excess of the community benchmark for length of stay and could be avoided. The American Legion disagrees since the VA population is sicker and older than the community. Furthermore, The American Legion questions the patient safety standards in the community. In December 1999, the Institute of Medicine found that approximately 98,000 Americans had died from medical errors. For this same time period VA, the largest single healthcare system in the country, reported 710 deaths related to adverse events. The private sector does not always deliver the best in health care and VA should not be forced to emulate those poor standards.

BAH assumes that the probability of enrollment will decrease over time, and that is simply not the case. VA enrollment has increased. Veterans who have never used the system are now doing so due to the outreach efforts of the networks coupled by the VSO's. In addition, new cases filed with the Veterans Benefits Administration have increased. These veterans will likely be referred to VHA for exams.

Vietnam veterans are reaching retirement age and will see a change in their health care benefits and coverage. Many of them will seek VA health care for the first time when they reach age 65. According to a recent study, 43 million American adults are uninsured and 36 million are employed. This population falls between being able to afford employer-based plans and government programs. If the Federal Employees Health Benefit Program is extended, it will cover an additional 13 million people. There is no evidence that BAH considered the rates of uninsured in its analysis, nor did they consider the cross over in the veteran population and the effect insurability in the private sector will have on veterans who will need to access the VA in the future.

In focusing on the quality of care BAH offers very little discussion on VA outperforming the private sector in several benchmark areas, particularly the Medicare program and death rates

from medical errors. VA has done better than Medicare in all of the key standards that Medicare identified for its providers. VA provides its patients aspirin, beta-blockers, ACE inhibitors, diabetes screenings, flu and phenomena shots, and mammography at a greater rate than Medicare.

Finally, The American Legion feels it is important to note that among leadership in the field and even in VA Central Office there is little behind the scenes support for CARES. Concerns over implementation and privatization are rampant. There is little faith that the private sector will be able to meet the challenging needs of a complex and aging veteran population. There is also very little evidence that the medical school affiliates are willing to fill the role assigned to them by BAH. Furthermore, the option to lease space is speculative since no such document has been developed. There are a great many unanswered questions and concerns about responsibility, accountability and retractability in these options. The American Legion opposes the methodology and conclusions of the CARES study thus far.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

Currently, this nation is faced with the largest aging veterans' population in its history. The number of veterans 65 years of age or older peaked at 9.3 million in the year 2000. By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half that number above 85 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older. The State Veterans Home Program must therefore continue, and even expand its role as an extremely vital asset to VA. Additionally, state homes are in a unique position to help meet the long-term care requirements of the Veterans' Millennium Health Care and Benefits Act.

State veterans' homes provide over 24,000 beds with a 90 percent occupancy rate that generate more than seven million days of patient care each year. The authorized bed capacity of these homes is 90 nursing care units in 40 states (17,844 beds); 46 domiciliaries in 32 states (5,841 beds); and 5 hospitals in 4 states (469 beds). For FY 2000, VA spent approximately $255 per day to care for each of their long term nursing care residents, while paying private-sector contract nursing homes an average per diem of $149 per contract veteran. The national average daily cost of caring for a state veterans' home nursing care resident during FY 2000 was $137. VA reimbursed state veterans' homes a per diem of only $40 per nursing care resident.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan. VA and its CARES contractor should work with the National Association of State Veterans' Home Directors to convert some of its underutilized facilities on large multi-building campuses to increase the number of available long-term care beds.

The American Legion recommends $110 million for the Grants for the State Extended Care Facilities for Fiscal Year 2003.

GI BILL OF HEALTH

The American Legion has outlined its top concerns for VHA throughout this testimony and offers the GI Bill of Health (GIBOH) as a blueprint for solving these problems for VHA in the 21st Century. The GIBOH transforms VHA into a nationwide veterans healthcare network serving all veterans (including those service members on active-duty and in the Reserves and national Guard).

The GIBOH would permit VHA to become a full partner with other federal and state healthcare insurers and providers including Medicare and Medicaid, DoD, the Indian Health Service, and the Public Health Service. The GIBOH would also augment Tricare and provide an enhanced focus on military retirees and their eligible dependents. There should be nothing that prevents VA and DoD from forging an agreement for a defined health benefits package for military retirees and their dependents. These departments, working together, should be able to provide attractive benefit packages to meet the health care needs of all veterans and eligible dependents. Under the GIBOH all veterans determined to meet the requirements for a core entitlement category will not be precluded from receiving any needed care, support services, supplies, devices, or diagnostic service.

The GIBOH will also provide VA the authority to define additional health benefit packages varying in scope and cost. Services covered in these benefit packages will range from the full continuum of care described for those core entitled, to a limited package that may exclude long-term care, ancillary services and other specialized programs depending upon the veteran's choice. Eligible veterans and their families could choose a benefit package based on their needs, interests, and the ability and willingness to offset its cost. In essence, the GI Bill of Health would provide the potential to substantially enhance VHA's ability to meet the growing health care needs of millions of Americans.

The GI Bill of Health would:

- Identify substantially new revenue sources, thereby reducing VHA's dependency on discretionary funding.
- Allow a veteran to enroll under a family plan that would include their spouses and minor/dependent children.
- Allow veterans, military retirees and their dependents to use existing Medicare, Medicaid, Tricare, third-party payers or employer health benefit plans to pay for treatment received at VA.
- Maintain that all special category veterans, indigent veterans and service-connected veterans rated less than 50 percent have access to VA health care services at no charge for service connected or a reduced charge for nonservice-connected conditions.
- Improve the long-term financial stability of VA's healthcare system by allowing VA to expand on all third-party reimbursements from other federal programs, third-party payers and employer health plans.
- Allow VA to retain and strengthen all specialized services.

MEDICARE SUBVENTION

Medicare subvention for VA, which is also a key component of the GIBOH, must be included in any planned Medicare reform legislation passed in the 107th Congress. Access to VA healthcare is an earned benefit. No Medicare-eligible veteran, treated for a nonservice-connected medical condition, should be deprived of his or her federal health- care insurance dollars to pay for the care received in a VA medical facility.

Currently, approximately 10.1 million veterans are Medicare-eligible based solely on their age. Criteria for Medicare-eligibility are different than eligibility for treatment in VA. In the VA healthcare network, certain veterans are eligible for treatment at no cost for medical conditions determined to be service-connected. Medicare-eligibility is not a priority or criteria for health care at no cost in the VA healthcare system. Other veterans are eligible for treatment at no cost because they are economically indigent. All other veterans must pay for treatment received.

Medicare subvention would allow VA to seek reimbursement from the Center for Medicare and Medicaid Services (formerly known as HCFA) for treatment of non-service connected medical conditions of Medicare-eligible veterans. VA and the Center for Medicare and Medicaid Services should explore the Fee-For-Service or Medicare+Choice options. Medicare-eligible veterans should not forfeit their Medicare healthcare dollars because they prefer VA health care to health care offered in the private sector.

More than 734,000 Medicare beneficiaries have lost HMO coverage over the past two years and another 934,000 seniors will be dropped by their HMO plans this year. Many VA-eligible beneficiaries are included in those dropped from coverage and are coming to VA for care. The argument that VHA is already reimbursed for its Medicare population and that Medicare subvention will result in double funding is mistaken. Medicare would only be billed for non-service connected conditions. VHA is mandated to provide care to all seven-priority groups, but not funded for all of their care. As more Medicare-eligible veterans seek first time care in VHA, healthcare costs and subsequent waiting times will increase. It is imperative that Congress examine this issue and take the actions necessary to ensure that VHA receives all funding necessary to execute its healthcare mission with quality and in a timely manner.

In addition, since VA outperforms the private sector Medicare provider, The American Legion believes that veterans using Medicare at VA would be getting better quality of care than if they were using those Medicare dollars in the private sector.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) is making great progress in meeting the interment needs of the nation's veterans and their dependents. Currently, 75 percent of all veterans live within 75 miles of open national or state veterans' cemeteries. The ultimate goal is to have 90 percent of all veterans living within 75 miles of open national or state veterans'

cemeteries. The 90th percentile is the maximum probability of reaching veterans who reside in extreme rural areas.

A commitment of $10 million, to the National Shrine Initiative will continue in FY 2002 for major improvements and renovations at the following national cemeteries: Long Island, NY; Los Angeles, CA; Golden Gate, CA; Ft. Snelling, MN; and Willamette, OR. The National Shrine Initiative will continue as a NCA priority.

NCA's workload is increasing by nearly five percent per year, with cremations accounting for the majority of new interments. The peak years for the interment of World War II veterans is expected to be 2006 to 2010. The new national cemetery at Ft. Sill, Oklahoma is anticipated to be open for burials by Veteran's Day, 2001. However, dedication of the cemetery will not occur until sometime in 2002. Over the next decade, new national cemeteries are also planned for Atlanta, GA; Miami, Fl; Pittsburgh, PA; Detroit, MI; Sacramento, CA; and St. Louis, MO. The Veterans' Millennium Act of 1998 (P.L. 106-117) required NCA to contract a study of where additional national and state veterans' cemeteries will be required through 2020.

NCA is preparing "fast track" construction projects to open new national cemeteries. This process would allow burials to occur in each section of a new cemetery as it is being constructed. Instead of the taking the conventional approach to new cemetery construction, "fast track" authority would permit the planned new national cemeteries to open in less than half the normal time, which is seven years.

The Director of the State Cemetery Grants Program, which provides 100 percent federal funding for new state veterans' cemeteries has significantly increased state cemetery applications. Within the next several years, NCA is hopeful that up to 30 new state veterans' cemeteries will be opened. New state cemetery grants applications currently total $120 million.

There is a pressing need to increase the burial and plot allowances for eligible veterans, and to increase the authorized burial allowance for the eligible dependent of a veteran who dies of service-connected causes. Congress must pass legislation to lift the restriction on providing veterans' headstones for previously marked graves. Several bills have been introduced in the 107th Congress concerning this issue.

There are significant minor construction project requirements throughout NCA. Currently, $17 million in minor construction funding is proposed for gravesite expansion projects in FY 2002. This limited funding will not permit necessary infrastructure repairs.

The American Legion recommends funding for NCA operations, the National Shrine Commitment, the State Cemetery Grants Program, and national cemetery minor construction projects in FY 2003 as follows:

- **National Cemetery Administration $125 million**
- **National Shrine Commitment $ 15 million**
- **NCA Total FY 2003 $140 million**

- **State Cemetery Grants Program $ 30 million**

- **NCA Minor Construction (infrastructure repairs and gravesite expansion - $35 million – (included in minor construction funding recommendation).**

VETERANS BENEFITS ADMINISTRATION

In response to continuing criticism from its veteran clientele, other stakeholders, and Congress, VBA has, within the last several years, begun implementing an ambitious plan to improve its overall operations. This includes the development of a broad spectrum of administrative, programmatic, and technological changes, which over time, are intended to dramatically improve both the level and quality of service provided by VBA offices. The American Legion has been strongly supportive of VBA's efforts to address the core problems affecting the claims adjudication and appeals process. However, we are deeply concerned by the serious breakdown in the quality and timeliness of services being provided to veterans by the 58 VBA field offices. VBA's ability to deliver the long-promised service improvements and operational efficiencies are being constantly undermined and diluted by the sheer number of pending claims and appeals and the lack of a sufficient number of trained claims processing staff. It is imperative that VBA receive the budgetary support in FY 2003 and beyond in order to maximize its chances of success. It is going to take sustained funding increases in order for VBA to continue efforts to reengineer its business processes, hire additional staff, improve training for both the new and more experienced employees, continue succession planning, and improve the overall quality and timeliness of the service provided to veterans and their families.

Mandatory spending for the payment of compensation, pension, and burial benefits by VBA for FY 2002 is projected to be $24.9 billion. For FY 2003, mandatory spending may exceed $26 billion. This figure reflects the impact of new regulatory and legislative entitlements as well as new proposed legislation and a cost-of-living-adjustment.

The challenge facing VBA because the current level of resource deficit will seriously jeopardize the successful implementation of the broad spectrum of operational, programmatic, technological, and administrative initiatives necessary to improve VBA operations and decision-making. The bottom-line is that disabled veterans must now wait months and sometimes years for their benefit claims to be decided. Because of such delay, many veterans will die before ever receiving a decision on their claim. They are chronically frustrated and disappointed by a bureaucratic system that appears to be insensitive to their personal problems and needs. It is critical that VBA's FY 2003 budget be sufficient to ensure that progress toward its service improvement goals will continue and that veterans and their survivors receive the benefits and in a reasonable period of time.

Today, there are more than 600,000 pending claims nationwide. This figure includes tens of thousand of cases waiting readjudication as a result of Congressional action overturning the decision in *Morton v. West*. There are also 28,000 remands from the Board of Veterans Appeals pending in the regional offices, many for two years or more. In addition, VA anticipates, over the next year, an influx of 80,500 new diabetes claims, 14,000 radiation claims, and an unknown number of hepatitis C claims. When finalized, these will result in a substantial number of claims

for disability compensation and VA medical care. While recently enacted legislation will assist veterans in establishing entitlement to disability and medical care benefits, we believe that Congress should codify by statute the presumptions which will apply to Hepatitis C claims. This will ensure VA has the necessary resources to fully and fairly adjudicate this type of claim and will provide the support needed for its outreach, information, and treatment programs. It is also estimated that 60,000 new appeals will be filed in FY 2001. Additionally, the Court of Appeals for Veterans Claims (CAVC), since its establishment in 1989, has historically remanded approximately 50 percent of the appeals from the Board of Veterans Appeals (BVA). Under these circumstances, it is little wonder that the regional offices cannot provide quality and timely services that veterans expect and deserve.

Secretary Principi has issued a number of directives to address this problem. One such initiative is the establishment of the Claims Processing Task Force with a mandate of 120 days to analyze the entire claims adjudication process and the Veterans Benefits Administration's computer systems. This task force is to provide recommendations to the Secretary on September 30, 2001. The American Legion has provided the task force with its views and will be very interested in their forthcoming findings and recommendations. The Secretary's goal is to have the backlog of pending claims reduced by half and average processing time down from 220 days to 100 days by mid-2003.

Mr. Chairmen, these are very laudable and ambitious goals, which will require overcoming formidable obstacles.

The American Legion offers several comments and recommendations in the areas of recruitment and staffing; training; management and administration; adjudication procedures; statutes and regulations. Given the magnitude and complexity of the immediate workload challenges facing VBA, the proposed increase in discretionary funding for FY 2002 will do little, if anything, to improve the claims adjudication process. Substantial progress cannot be achieved without additional staffing in the regional offices, over and above the 1,200 FTE hired in the last two years. Trainees with less than two years of experience already make up a large percentage of VBA's workforce. Recruitment, however, is only one part of the equation. Veterans' benefits claims are becoming increasingly complex, both medically and legally. VBA must put a priority on providing new employees, as well as the more experienced adjudicators with comprehensive and intensive training. The need for more trained personnel will increase as the workload associated with new claims for diseases such as diabetes related to Agent Orange exposure, hepatitis C, and radiation-related claims increases. In addition, there is a steady influx of newly initiated appeals as well as a high number of pending remand cases from the Board of Veterans Appeals. If it is to be successful in achieving a substantial reduction in the claims backlog, VBA must make training and quality assurance programs the high priorities. Decision-makers must have the necessary knowledge and tools to properly do their job, along with rigorous quality assurance and management support.

Secretary Principi has directed that Decision Review Officers should only work on appeal cases fifty percent of the time and work on original and reopened claims the remaining fifty percent of the time. We believe that this is an inefficient use of a valuable resource. The DRO's function is to try to resolve appeals at the regional office level. They also have a training

function. In the long-term, these efforts will reduce the appellate workload both at the regional office and at the Board.

By making certain changes in the pension program, VBA expects to achieve substantial operating efficiencies, which will free up personnel who can then be assigned to processing compensation claims. From a conceptual standpoint, it would appear that personnel savings could result from centralizing or consolidating the processing of adjustments to pension claims. However, The American Legion has very serious objections to any such changes. In the early 1990's, processing of Persian Gulf War claims was consolidated, this proved to be unsuccessful and was subsequently discontinued. Adjustments to running pension awards may appear to be a simple process, but it is not. Transferring the file to a central processing center would make the veteran's file unavailable to the local accredited representative as well as the veteran. Information on the case would be difficult to obtain. This would also adversely affect the veteran's ability to request a waiver, have a hearing before the Committee on Waivers and Compromises, or to complete action on a pending claim for compensation.

VBA Recruitment and Staffing

- VBA should recruit those individuals retiring or separating from active duty. Consideration should also be given to waiving the requirement of a college degree if they have comparable military training and experience in certain areas.
- New VBA employees should be immersed in an intensive indoctrination program that will improve VA's overall mission to assist and advocate for veterans and their role in this process. This training should include the participation of the VSOs.
- We believe the indoctrination phase should be integrated into a formal mentoring program involving senior adjudication personnel. Measurable standards and criteria for completion should be developed.
- VBA should look at the skill levels required for entry level positions and how these relate to opportunities for advancement and promotions. In many instances, these positions are phased out in favor of using work-studies.
- Regional office Human Resources Offices need to be more involved in management planning and decision making in hiring and retention practices.

Training

VBA must continue to invest in training. This is the only way to improve production. Unless, and until, claims are decided correctly, time will be wasted, scarce Federal resources will be squandered, and veterans will be done a disservice.

Management and Administration

- Managers and supervisors must be held personally accountable for the quality of work being performed at a station, along with the adjudicators. There must be incentives for doing good work and disincentives to doing poor quality work.
- There must be a better balance between local management autonomy and central direction in setting consistent management priorities.

- More training and central office support is needed to avoid crisis management.
- The Service Delivery Networks (SDNs) should reexamine the way "brokered work" is handled to ensure there is greater consistency and quality.
- Mangers need to develop standards by which they evaluate and hold employees accountable. Performance Measures should be used to track quality improvement.
- The records management system procedures must be followed to prevent lost files. Time is wasted searching for files and processing is delayed.
- Many local and central office-mandated special projects, such as special reviews, West Ball, etc, are very time consuming and take senior managers and adjudicators away from claims processing. A coordinated effort should be made to control the number of regional office special projects.

Adjudication Procedures

- Where a veteran has been treated by the same VA physician or clinic for a number of years, a protocol should be implemented that will provide sufficient medical information for rating purposes without the need to schedule a special C&P exam.

The American Legion recommends a funding level of $1.3 billion for VBA-GOE appropriations for Fiscal Year 2003.

TOBACCO-RELATED CLAIMS

The American Legion believes that with the passage of PL 105-206, the Transportation Equity Act for the 21st Century, the 105th Congress turned its back on tens of thousands of veterans who have developed tobacco-related illnesses. There is a conscious decision to ignore the federal government's historical role in promoting the use of tobacco products by the members of the armed forces. With this legislation, the majority were willing to put politics before principle and take away a veterans' right to file a claim with the Department of Veterans Affairs for a disability (or death) that began during or resulted from their active military service. The American Legion urges Congress to recognize the injustice that was done and remove this arbitrary bar to benefits.

In 1993, the VA General Counsel determined that VA could establish service connection for a disability or death that was traceable to the veteran's use of tobacco products during their period of military service. Once service connection was granted, compensation would be payable based on the severity of the disability. This would also entitle them to priority VA medical care. Despite this ruling, VA deferred adjudicating any tobacco-related claims until 1997, when a second VA General Counsel opinion confirmed the 1993 determination. Rather than acknowledging the federal government's responsibility to redress veterans for tobacco-related illnesses, the administration proposed legislation to deny benefits for any tobacco-related disease acquired after discharge from service. VA provided questionable data in support of the legislation. VA claimed it would be inundated with a half million claims or more and the cost would be $15 billion. Even though VA's own data proved to be erroneous, with less than 9,000 claims received between 1993-1997, with total payments of less than $60 million, Congress passed this anti-veteran legislation over the strenuous objections of The American Legion and

the other veterans' service organizations. Tobacco use in service is now portrayed as synonymous with willful misconduct, despite scientific studies indicating that nicotine is highly addictive, and the military's role in initially promoting its use. It is our hope that this congress will overturn this biased ruling and restore veterans rights to benefits and services available through VA. The American Legion also urges Congress to consider the actions taken in 1994 by the British government when it granted compensation for smoking related diseases for its veterans.

ATOMIC VETERANS

The American Legion remains concerned by the lack of progress on issues relating to atomic veterans and their claims for service connected disability and death benefits. The complex and often arbitrary rules and regulations that effectively prevent them from receiving VA benefits have long frustrated this unique population of veterans. We have continued to support both the expansion of the list of recognized radiogenic diseases and the definition of a radiation-risk activity set forth in title 38, United States Code.

Last year, with considerable fanfare, VA announced it intended to recognize additional radiation-related diseases, in an effort to ensure comparability between VA disability compensation and the Department of Justice's Radiation Compensation Act programs. VA was going to develop new proposed regulations which would have the same exposure standards that apply to benefits for certain civilian workers in the nuclear weapons field be utilized in VA claims. The criteria applicable to those Department of Energy (DOE) civilian workers under the Radiation Exposure Compensation Act (RECA) of 1990, as amended, provides that such workers may be compensated for diseases related to radiation exposure as well as exposure to beryllium and silica. Following this announcement, The American Legion recommended to VA that, in the interests of equity, VA should apply the RECA standards to veterans who served on active duty at all DOE nuclear weapons development, testing, and manufacturing facilities, including Hanford, WA, and not just those enumerated in the announcement. These veterans should be presumed to have been exposed to the same health hazards and risks from radiation and other hazardous materials as their civilian co-workers.

The new presumptions applicable to claims by atomic veterans have yet to be published for public comment. However, it remains clear that the requirements of 38 CFR 3.311 for a radiation dose estimate will still make it very difficult for many veterans to get all of the benefits intended by this change. In PL 106-419, Congress expressed its concern with the lack of reliable radiation dose estimates and the adverse effect this has on the adjudication process. VA has been mandated to conduct a multi-year study of the accuracy and reliability of the dose reconstruction program through the National Academy. In the meantime, legislation has been introduced that we believe will help bring a greater degree of equity for atomic veterans, their families, and their survivors. We remain optimistic that Congress will expand the list of presumptive radiation related diseases, include duty at nuclear weapons facilities, and eliminate the dose reconstruction requirement in radiation-exposure claims.

BOARD OF VETERANS APPEALS (BVA)

The American Legion is supportive of the Board's efforts to improve productivity and reduce response times. Staffing at the BVA is currently 479 FTE. However, due to a number of internal and external factors, the BVA's workload is expected to remain heavy and their response time in FY 2002 is expected to decrease to 590 days.

We believe the modest gains expected in production in FY 2002 and reduced appeals resolution time, will be largely offset by the new appeals associated with the implementation of the Veterans Claims Assistance Act of 2000 and the precedent decisions of the Court of Appeals for Veterans Claims. The Board will require additional time, effort and resources in order to fully and fairly decide appeals of regional office decisions and those cases remanded from the Court to the Board for readjudication.

The American Legion remains concerned by the long-term upward trend of the Board's workload. This is despite VBA's many quality and service improvement initiatives, including the establishment of the Decision Review Officer program and greater cooperation between the regional offices and the BVA. The fact remains that some 60,000 new appeals, on average, are filed each year. Of those cases decided by the Board, the regional office's action will be overturned completely in one quarter of the cases. However, coordinated efforts by the Board and the regional offices have, in fact reduced the remand rate from approximately fifty percent to about thirty percent. However, there are thousands of cases that have been remanded to the regional offices over the last several years, which are still outstanding. It is currently taking 2-3 years for the regional office to complete the action directed by the Board. A majority of these will ultimately return to the BVA for another decision. Remanded cases often take 2-3 years for the regional offices to complete the directed action. Clearly, there remains a serious quality problem in regional office decision-making, which continues to affect the Board's workload and resource needs.

The American Legion recognizes that the Board is in a state of transition. We believe that there has been a realization that these programs are closely interrelated and interdependent. The Board has established a strategic plan to improve its operating efficiency. This includes greater cooperation and involvement with efforts to improve regional office decision-making and appeals resolution. The American Legion believes there is a continued need to provide support to the Board's strategic plans to improve the overall quality and timeliness of service to veterans. We urge Congress to provide the necessary resources to the Board in order for it to carry out these plans.

VETERANS EDUCATION BENEFITS

ALL-VOLUNTEER FORCE EDUCATIONAL ASSISTANCE PROGRAM

The American Legion commends the 107th Congress for its recent actions to improve the current Montgomery GI Bill (MGIB). A stronger MGIB is necessary to provide the nation with the caliber of individuals needed in today's Armed Forces. The American Legion appreciates the efforts that this Congress has made to address the overall recruitment needs of the Armed

Forces and to focus on the current and future educational requirements of the All-Volunteer Force.

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. This we believe is directly related to the fact that current GI Bill benefits have not kept pace with increased costs of education. Costs for attending the average four-year public institution as a commuter student during the 1999-2000 academic year were nearly $9,000. PL 106-419 recently raised the basic monthly rate of reimbursement under MGIB to $650 per month for a successful four-year enlistment and $528 for an individual whose initial active duty obligation was less than three years. The current educational assistance allowance for persons training full-time under the MGIB – Selected Reserve is $263 per month. Although a step in the right direction, the MGIB educational allowance improvements enacted under PL 106-419 have not addressed the fundamental shortcomings of the program. Data today suggests that only one-fourth of all enlistees who enroll in MGIB complete a four-year college degree.

The Servicemen's Readjustment Act of 1944, the original GI Bill, provided millions of members of our Armed Forces an opportunity to seek higher education. Many of these individuals may not have taken advantage of this opportunity without the generous provisions of that act. Consequently, these servicemen and servicewomen made a substantial contribution to not only their own careers, but to the well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational costs of the World War II bill were $14.5 billion. The Department of Labor estimated that the government actually made a profit because veterans earned more and therefore paid more taxes. Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only taking the necessary steps to enhance their own careers, but also, by doing so, will make a greater contribution to their community, state, and nation.

The American Legion recommends the following improvement to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify

- The educational cost index should be reviewed and adjusted annually,

- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package,

- Enrollment in the MGIB shall be automatic upon enlistment, however, benefits will not be awarded unless eligibility criteria have been met,

- The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated,

- If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay existing educational loans,

- If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of Title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB,

- A veteran may request an accelerated payment of all monthly educational benefits upon meeting the criteria for eligibility for MGIB financial payments, with the payment provided directly to the educational institution.

- Separating service members and veterans seeking a license or credential must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device,

- Eligible veterans shall have 10 years after discharge to utilize MGIB educational benefits,

- Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years from their date of separation to use MGIB educational benefits.

The American Legion believes that all of the above provisions are equally important to providing the necessary enhancements to the MGIB.

VETERANS' EMPLOYMENT AND TRAINING PROGRAMS (VETS)

The mission of the Department of Labor's Veterans Employment and Training Service (VETS) is to promote the economic security of America's veterans. This is accomplished by reducing unemployment and underemployment among veterans with service connected disabilities and other veterans.

On an annual basis, the Department of Defense (DoD) discharges approximately 250,000 service members, many of which are job ready or intend to continue their education. However, of those discharged, many transitioning service members will seek gainful employment. VETS plays a significant roll in helping recently separated service members in their employment efforts.

Over the past several years, VETS has expanded its outreach efforts by starting certain initiatives designed to improve the economic status of veterans and transitioning service members, and helping employers find applicants with the skills they are looking for in today's labor market. VETS has taken the lead in identifying military occupations that need licenses,

certificates or other credentials and is taking action to eliminate barriers to service members' transition from military service to the civilian labor market. VETS new Internet site – UMET ("Use your Military Experience and Training") provides separating military personnel with information about those occupations in which most active duty separations occur. UMET also identifies any gaps in experience or training that may exist that need to be overcome in order to work in the civilian sector in that occupation.

VETS also recently started an information technology project with the Computing Technologies Industry Association, to recruit veterans recently separated from the military; assess their interest and skill level for a career in information technology; provide occupational skills training and certification; and place these veterans into information technology jobs.

VETS continues to expand its PROVET (Providing Re-employment Opportunities for Veterans) program. PROVET is an employer-focused job development and placement program that focuses on screening, matching and placing job ready transitioning service members into career-building jobs. PROVET programs are currently operating in Tennessee and Texas and will soon be expanded to other states.

In additional to employment services, VETS also supports DOD's Transition Assistance Program (TAP), Veteran's Preference in the Federal workplace, grant's administration functions, and the Uniformed Services Employment and Re-employment Rights Act (USERRA).

The American Legion is extremely disappointed with the recent budget trends within VETS. The Administration's budget request for the VETS program in Fiscal Year 2002 is $211.7 million, which includes $186.9 million from the Employment Security account in the Unemployment Trust Fund and $24.8 million from general funds. This request is essentially the same as current service levels.

The Disabled Veterans' Outreach Program (DVOP) and the Local Veterans Employment Representative (LVER) program have been virtually flat-lined in budget authority since Fiscal Year (FY) 1992. In FY 1992 the programs were funded and staffed as follows:

- FY 1992 DVOP funding - $82 million
- FY 1992 LVER funding – $76.1 million
- FY 1992 Actual DVOP staffing – 1,754 FTE
- FY 1992 Actual LVER staffing – 1,532 FTE

In contrast, FY 2001 funding and staffing are:

- FY 2001 DVOP funding - $81.6 million
- FY 2001 LVER funding - $77.3 million
- FY 2001 Actual DVOP staffing – 1,306 FTE
- FY 2001 Actual LVER staffing – 1,252 FTE

From their peak funding and staffing levels of FY 1994, which coincided with the draw down of the Armed Forces, these two programs have reduced personnel in order to adjust to their annual

budgets. Yet today, the number of registered veterans has increased and the number of veterans placed in training is higher than in FY 1992. *Simply put, the DVOP and LVER programs are not serving the veteran community in the most effective manner due to significant shortfalls in funding and staffing.* This situation must be reversed.

Surprisingly, the Administration's budget request for the DVOP and LVER grants-to-States program for FY 2002 totals $158.9 million; the same amount as in FY 2001. These programs are unique in that they are funded through the Unemployment Insurance Trust Fund.

The American Legion respectively supports an additional $54 million and $38 million for the DVOP and LVER programs for FY 2003 funding. These increases will allow the programs to increase staffing to adequately provide comprehensive case management job assistance to disabled and other eligible veterans.

The American Legion recommends that $5 million of VETS funding is targeted toward incarcerated veterans' education and transition assistance programs beginning in FY 2003. Currently there is minimal to no efforts being made in providing meaningful outreach to incarcerated veterans. All too often, the state prison systems are not providing adequate vocational and life skills training to inmates that are nearing their release dates. VETS could provide meaningful assistance to veteran inmates. The Federal government, in cooperation with individual states, must provide effective outreach services to incarcerated veterans to assist in a successful transition to a crime free civilian life.

The American Legion also believes that funding for the Homeless Veterans' Reintegration Program (HVRP), Transition Assistance Program, VETS Administration, and the National Veterans' Training Institute (NVTI) all require appropriate funding increases. These particular programs are funded through general appropriations.

The NVTI program in Denver, Colorado has been flat lined at $2 million for nearly eight years. The program currently maintains a waiting list of 1,500 new employees, nearly one-half of all DVOPs and LVERs. It takes over one year once hired to receive training at NVTI. **The American Legion recommends an increase in the NVTI budget to $3 million annually.**

The VETS program is one of the best-kept secrets in the Federal government. It is comprised of many dedicated individuals who simply cannot maintain a quality program without substantial funding and staffing increases. Staffing is so strained within VETS that the service would be hard-pressed to appropriately administer any significant increase in HVRP funding. The American Legion believes the VETS program is a good investment; one that actually returns money to the United States Treasury. This program cannot continue to be neglected without experiencing a serious diminution in service.

The American Legion recommends a funding level of $300 million for the Veterans' Employment and Training Service in FY 2003.

SUMMARY

Messrs. Chairmen and Members of these Committees, in this statement, I have laid out the priorities of The American Legion regarding the many programs and services made available to the veterans of this nation and to their dependents and survivors.

The American Legion has outlined many central issues in our testimony today. Veteran's health care, VA/DoD sharing, the nursing shortage, the claims back log, atomic veterans, Gulf War Illnesses, education, and CARES will influence the funding requirements for the Department of Veterans Affairs. The GI Bill of Health along with Medicare subvention are two of the proposals The American Legion envisions will augment this funding need.

We realize there are many important issues before the Congress of the United States. However, The American Legion believes that Congress must focus on finding effective solutions to veterans' concerns. The veterans of this nation have always answered when their country called. Medals, awards, and citations recognize the remarkable achievements of citizen soldiers, sailors, airmen and Marines, but the true gratitude paid to America's veterans comes in the form of meeting their post-military needs, especially those with any service-connected disabilities. The American Legion believes it is time to make a meaningful commitment to the programs and services that are an earned recognition for our veterans from a truly grateful nation.

Thank you for granting me the opportunity to appear before you today.